The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066 (402) 361-7300

CERTIFIES THAT Group Policy No. 00040500417600000 has been issued to
Loyola University New Orleans
(The Group Policyholder)

The Issue Date of the Policy is January 1, 2016.

Certificate of Insurance for Class 1

You are entitled to the benefits described in this Certificate only if you are eligible, become and remain insured under the provisions of the Policy. If you have elected Dependent coverage on your enrollment form, your Dependents are covered under this Certificate only if such Dependents are eligible for insurance under the Policy and the required premium has been paid. This Certificate replaces any other certificates for the benefits described inside. As a Certificate of Insurance, it is not a contract of insurance; it only summarizes the provisions of the Policy and is subject to the Policy's terms. If the provisions of this Certificate and the Policy do not agree, the provisions of the Policy will apply.

READ YOUR CERTIFICATE CAREFULLY

This is a limited benefit certificate. It provides Critical Illness insurance coverage. There is no coverage for hospital, medical-surgical or major medical expenses.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

CERTIFICATE OF GROUP CRITICAL ILLNESS INSURANCE

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Loyola University New Orleans
00040500417600000

SCHEDULE OF BENEFITS

For Class 1

ELIGIBLE CLASS means: All Full-Time Employees

MINIMUM HOURS PER WEEK: 30

ANNUAL/OPEN ENROLLMENT PERIOD: December 1 – December 31

ELIGIBILITY WAITING PERIOD (For Date Insurance Begins, Refer To "Effective Date" Section).

None

CONTRIBUTIONS: You are required to contribute to the cost for Personal Critical Illness Insurance and to the cost for Dependent Critical Illness Insurance.

SCHEDULE OF BENEFITS
(Continued)

PERSONAL CRITICAL ILLNESS INSURANCE

	Personal Critical Illness Principal Sum
Class 1	
(Option as elected by you)	
Option 1	$10,000
Option 2	$20,000

DEPENDENT CRITICAL ILLNESS INSURANCE
(For Class 1)

Dependent Spouse	Dependent Critical Illness Principal Sum
(Option as elected by you)	
Option 1	$5,000
Option 2	$10,000
Dependent Child	
(Option as elected by you)	
Option 1	$5,000

HEART CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	**Percentage of Principal Sum**
Heart Attack	100%
Placement on United Network for Organ Sharing (UNOS) List for Heart Transplant*	100%
Stroke	100%
Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments
Aneurysm due to Arteriosclerosis	10%, subject to a lifetime maximum of 2 payments

CANCER CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
Cancer	100%
Cancer in Situ	25%
Benign Brain Tumor	25%
Placement on the Be the Match Registry for Bone Marrow Transplant*	25%

ORGAN CATEGORY (Available for Insured Persons and Dependents)

Event/Illness	Percentage of Principal Sum
End Stage Renal Failure	100%
Placement on United Network for Organ Sharing (UNOS) List for Major Organ Transplant (excluding Heart)*	100%
Acute Respiratory Distress Syndrome	25%

WELLNESS CATEGORY (Available for Insured Persons and Dependents)

Critical Illness Assessment Benefit

Critical Illness Assessment Period:	January 1st through December 31st
Critical Illness Assessment Benefit:	$50 for each Critical Illness Assessment Test performed, subject to a maximum of 1 Critical Illness Assessment Test per person per Critical Illness Assessment Period

Child Care Expense Benefit $25 per Child per day

For you or each of your Insured Dependents, the lifetime total benefits payable in any category shown in the Schedule of Benefits (except the Wellness Category) are subject to an overall maximum of 200% of the Principal Sum.

*A benefit for this Event may also be payable if you or your Insured Dependent:
(1) is determined to be too ill for a transplant, but otherwise meet the criteria for placement on the network/registry; or
(2) receives a transplant prior to placement on the network/registry.

EVIDENCE OF INSURABILITY. Evidence of Insurability satisfactory to the Company must be submitted when:

(1) Critical Illness Insurance amounts exceed the guarantee issue amount of $20,000 for Insured Persons or $10,000 for Insured Dependent Spouses at initial enrollment;
(2) the amount of Critical Illness Insurance increases after the initial enrollment; or
(3) initial coverage is elected more than 31 days after first becoming eligible.

DEFINITIONS

ACTIVE WORK or ACTIVELY AT WORK means an Employee's performance of all customary duties of his or her occupation at:

(1) the Group Policyholder's place of business; or
(2) any other business location designated by the Group Policyholder.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Group Policyholder's prior approval or on an emergency basis.

ACUTE RESPIRATORY DISTRESS SYNDROME means acute respiratory failure resulting in inadequate oxygenation, due to aspiration or infection. Diagnosis is determined by a Physician and based on:

(1) demonstration of infiltrates in both lungs in the absence of clinical heart failure; and
(2) acute lung injury demonstrated by testing of blood gases.

ALTERNATE CARE OR REHABILITATIVE FACILITY means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

ANEURYSM DUE TO ARTERIOSCLEROSIS means an abnormal widening or ballooning of a portion of an artery due to weakness of the arterial wall caused by Arteriosclerosis, of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Aneurysm is diagnosed by a Physician based on arteriography or other appropriate imaging studies.

ANNUAL/OPEN ENROLLMENT PERIOD means the period in the calendar year, not to exceed 31 days, during which the Group Policyholder allows eligible Employees to purchase or make changes to their Personal or Dependent Critical Illness Insurance.

Participation in an Annual/Open Enrollment Period does not change Policy provisions related to the Eligibility Waiting Period.

ARTERIOSCLEROSIS means blockage of a coronary artery of sufficient severity to require angioplasty, stent placement, atherectomy, or bypass. Diagnosis is made by a board-certified or board-eligible cardiologist and is accompanied by the demonstrated need for intervention.

BENIGN BRAIN TUMOR means a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. Diagnosis of the tumor and neurological deficit must be confirmed by imaging and examination findings conducted by a board-certified or board-eligible neurologist or other Physician appropriately licensed to diagnose the deficit.

BONE MARROW TRANSPLANT means a transplant necessitated by a compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis is made by a board-certified or board-eligible hematologist or board-certified or board-eligible oncologist who determines that the bone marrow transplant is necessary and places the Insured Person or Insured Dependent on the Be The Match registry. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the registry; the registry requirement will be waived. The registry requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the registry.

CANCER means malignant cells or tumors characterized by uncontrolled growth with spread beyond the initial tissue. Diagnosis must be by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic tissue evaluation (biopsy). The following are not considered Cancer for purposes of this definition:

(1) Cancer in Situ;
(2) basal cell carcinoma and squamous cell carcinoma of the skin; and
(3) melanoma that is diagnosed as Clark's level I or II, or Breslow less than 0.75 mm.

CANCER IN SITU means Cancer cells confined to the surface tissues (epithelium) without invasion of the basement membrane and with no spread to regional lymph nodes or other tissues. Diagnosis is made by a board-certified or board-eligible oncologist or board-certified or board-eligible pathologist and based on microscopic examination of tissue (biopsy). Basal cell and squamous cell carcinomas of the skin are not considered Cancer in Situ.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY OR DATE means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, at the Group Policyholder's place of business, when used with regard to eligibility dates and effective dates. When used with regard to termination dates, it means 12:00 midnight, at the same place.

DEPENDENT CRITICAL ILLNESS INSURANCE means the coverage provided by the Policy for eligible Dependents.

ELIGIBILITY WAITING PERIOD means the period of time a Person must be in an eligible class with the Group Policyholder, before he or she becomes eligible to enroll for insurance under the Policy.

EMPLOYEE means a Full-Time Employee of the Group Policyholder.

END STAGE RENAL FAILURE means chronic and irreversible failure of the kidneys of such magnitude that permanent dialysis or transplant is required to sustain life.

EVENT/ILLNESS means a Critical Illness event or illness:
(1) shown in the Schedule of Benefits; and
(2) for which the Insured Person or Insured Dependent is covered under the Policy.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:
(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Group Policyholder's leave policy and the law which applies; and
(3) does not exceed the period approved by the Group Policyholder and required by that law.

The leave period may:
(1) consist of consecutive or intermittent work days; or
(2) be granted on a part-time equivalency basis.

If a Person is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If a Person is on an FMLA leave due to his or her own health condition on the date insurance under the Policy takes effect, he or she is not considered Actively at Work.

FULL-TIME EMPLOYEE means a person:

(1) whose employment with the Group Policyholder is the person's main occupation;
(2) whose employment is for regular wage or salary;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Benefits per week;
(4) who is a member of an eligible class under the Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

GROUP POLICYHOLDER means the person, partnership, corporation, trust, or other organization, as shown on the Title Page of the Policy.

HEART ATTACK (MYOCARDIAL INFARCTION) means death of a portion of heart muscle due to inadequate circulation in coronary arteries. If no death of heart muscle occurs, this is not considered a heart attack. Diagnosis is made by a board-certified or board-eligible cardiologist and based on findings from an electrocardiogram (EKG) and elevation of cardiac enzymes associated with heart attack.

HEART TRANSPLANT means the transplantation of a healthy heart from a suitable donor, necessitated by the diagnosis of end-stage heart disease, as determined by a Physician appropriately specialized for the heart. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the network.

HOSPITAL means a general hospital which:

(1) is licensed, approved or certified by the state where it is located;
(2) is recognized by the Joint Commission;
(3) is operated to treat Inpatients;
(4) has a registered nurse always on duty; and
(5) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions, either on its premises or in facilities available to it on a prearranged basis.

It does not include a place that:

(1) is specialized solely in dentistry, mental illness or substance abuse;
(2) is a rest home, home for the aged, convalescent home or nursing home; or
(3) Alternate Care or Rehabilitative Facility, extended care or skilled nursing facility.

INPATIENT means an Insured Person or Insured Dependent who is an overnight resident patient.

INSURANCE MONTH means that period of time:
(1) beginning at 12:01 a.m. on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month;
at the Group Policyholder's primary place of business.

INSURED DEPENDENT means a Dependent for whom Policy coverage is in effect.

INSURED DEPENDENT SPOUSE means the Insured Person's spouse for whom coverage is in effect.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAJOR ORGAN means the liver, lungs, pancreas, intestines, or combinations of these organs.

MAJOR ORGAN TRANSPLANT means the transplantation of a healthy Major Organ from a suitable donor, necessitated by the diagnosis of end-stage organ disease (organ failure), as determined by a Physician appropriately specialized for the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If the Insured Person or Insured Dependent is determined to be too ill for a transplant, but otherwise meets the criteria for placement on the UNOS list, the network requirement will be waived. The network requirement will also be waived if the Insured Person or Insured Dependent receives the transplant prior to placement on the network.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Group Policyholder's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

PAYROLL PERIOD means that period of time established by the Group Policyholder for payment of employee wages.

PERSON means a Full-Time Employee of the Group Policyholder:
(1) who is a member of a class that is eligible for insurance under the Policy; and
(2) who has completed an enrollment form.

PERSONAL CRITICAL ILLNESS INSURANCE means the insurance provided by the Policy for Insured Persons.

PHYSICIAN means:

(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

(1) the Insured Person's spouse, siblings, parents, children and grandparents; and
(2) his or her spouse's relatives of like degree.

POLICY means this Group Critical Illness Insurance policy issued by the Company to the Group Policyholder.

PREMIUM means the amount charged for insurance coverage.

STROKE means permanent neurological damage to the brain due to inadequate blood flow in any of the cranial vessels, due to either blockage or rupture of the vessel and categorized as Score 3 on the Modified Rankin Scale. Diagnosis of permanent neurological damage should be made by a neurologist and demonstrated by imaging (CT or MRI) and examination demonstrating lasting neurological deficits (motor, cognitive, or sensory). Transient Ischemic Attacks (TIA) are not considered Strokes.

YOU and YOUR means an eligible Employee for whom the coverage provided by the Policy is in effect.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties consists of:
(1) the Policy and any amendments to it; and
(2) the Group Policyholder's application.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons or Insured Dependents are representations and not warranties. No statement made by an Insured Person or Insured Dependent will be used to contest the insurance provided by the Policy, unless:
(1) it is contained in a written statement signed by that Insured Person or Insured Dependent; and
(2) a copy of the statement has been furnished to that Insured Person or Insured Dependent.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of the Policy after it has been in force for two years from its date of issue; and as to any Insured Person or Insured Dependent, after his or her insurance has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) the Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of insurance.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) an Insured Person or Insured Dependent incurs a claim during the first two years of coverage; and
(2) the Company discovers that the Insured Person or Insured Dependent made a Material Misrepresentation on his or her application.

A "**Material Misrepresentation**" is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. "**To rescind**" means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for Insured Person's or Insured Dependent's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

MISSTATEMENT OF FACTS. If relevant facts about any Insured Person or Insured Dependent were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under the Policy.
If any Insured Person's or Insured Dependent's age has been misstated and the amount of benefit depends upon age; then the benefit will be that which would have been payable, based upon his or her correct age.

GROUP POLICYHOLDER'S AGENCY. For all purposes of the Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CURRENCY. In administering the Policy all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. The Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ELIGIBILITY AND EFFECTIVE DATES FOR PERSONAL CRITICAL ILLNESS INSURANCE

ELIGIBILITY. A Person becomes eligible for insurance provided by the Policy on the later of:

(1) the Policy's date of issue; or
(2) the date the Waiting Period is completed. (For Waiting Period, see Schedule of Benefits).

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Benefits. Prior service in an Eligible Class will apply toward the Waiting Period, when:

(1) a former employee is rehired within six months after his or her employment ends; or
(2) an employee returns from an approved Family or Medical Leave within:
    (a) the leave period required by federal law; or
    (b) any longer period required by a similar state law; or
(3) an employee returns from a Military Leave within the period required by federal USERRA law.

ENROLLMENT. A Person may enroll for Personal Critical Illness Insurance only during any Annual/Open Enrollment Period.

EFFECTIVE DATE. Personal Critical Illness Insurance becomes effective on the latest of:

(1) the Policy Anniversary Date immediately following the Annual/Open Enrollment Period in which you become eligible for the insurance;
(2) the first day of the Insurance Month coinciding with or next following the date you resume Active Work, if not Actively at Work on the day you become eligible (You will be deemed Actively at Work on any regular non-working day, if you:
    (a) are not totally disabled or Hospital confined on that day; and
    (b) were Actively at Work on the regular working day before that day);
(3) if you contribute to the cost of the Personal Critical Illness Insurance, first day of the Insurance Month coinciding with or next following the date you make written application for insurance and pay the required premium to the Company; or
(4) the first day of the Insurance Month coinciding with or next following the date the Company approves your Evidence of Insurability, if required. (See Schedule of Benefits.)

Any increase in insurance or benefits becomes effective at 12:01 a.m. on the latest of:

(1) the Policy Anniversary Date immediately following the Annual/Open Enrollment Period in which you become eligible for the increase, if Actively at Work on that day;
(2) the first day of the Insurance Month coinciding with or next following the date you resume Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the first day of the Insurance Month coinciding with or next following the date any required Evidence of Insurability is approved by the Company. (See Schedule of Benefits).

Any reduction in insurance or benefits will take effect on the day of the change, whether or not you are Actively at Work.

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Personal Critical Illness Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period. (See Schedule of Benefits).

ELIGIBILITY AND EFFECTIVE DATES FOR
PERSONAL CRITICAL ILLNESS INSURANCE
(Continued)

REINSTATEMENT RIGHTS. If your insurance terminates due to one of the following breaks in service, you will be entitled to reinstate the insurance upon resuming Active Work with the Group Policyholder within the required timeframe. "**Reinstatement**" or "**to reinstate**" means to re-enroll for the Policy's insurance coverage, without satisfying a new Eligibility Waiting Period. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
    (a) the period required by federal law; or
    (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within 6 months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate insurance coverage, you must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an eligible class unless the Group Policyholder contributes the entire cost of the premium. The required premium payments must be received from the Group Policyholder for coverage to be reinstated. Reinstatement will take effect on the date you return to Active Work.

TERMINATION OF PERSONAL CRITICAL ILLNESS INSURANCE

TERMINATION. Your insurance will terminate at 12:00 midnight on the earliest of:

(1) the date the Policy terminates (but without prejudice to any claim incurred prior to termination);
(2) the date your Class is no longer eligible for insurance;
(3) the date you cease to be a member of the Eligible Class;
(4) the last day of the Insurance Month in which you request termination;
(5) the last day of the last Insurance Month for which premium payment is made on your behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of the Policy providing that type of benefit terminates;
(8) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category;
(9) the date you cease to be covered under at least one category other than the Wellness Category;
(10) the date your employment with the Group Policyholder terminates; or
(11) the date you enter armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium);

unless insurance is continued as provided below.

CONTINUATION RIGHTS. Ceasing Active Work results in termination of your eligibility for insurance, but insurance may be continued as follows.

Disability. If you are disabled due to an event or illness shown in the Schedule of Benefits, then insurance may be continued until the earlier of:

(1) 12 Insurance Months after the disability begins; or
(2) the date you are no longer disabled.

The required premium payments must be received from the Group Policyholder, throughout the period of continued insurance.

Family or Medical Leave. If you go on an approved Family or Medical Leave and are **not** entitled to any more favorable continuation available during disability, insurance may be continued until the earliest of:

(1) the end of the leave period approved by the Group Policyholder;
(2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date you notify the Group Policyholder that you will not return; or
(4) the date you begin employment with another employer.

The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

Military Leave. If you go on a Military Leave, insurance may be continued for the same period allowed for an approved Family or Medical Leave or any more favorable leave in which employees with similar seniority, status, and pay who are on furlough or leave of absence are granted by the Group Policyholder. The required premium payments must be received from the Group Policyholder throughout the period of continued insurance.

Conditions. In administering the above continuations, the Group Policyholder must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may not be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

PORTABILITY. If insurance under the Policy would end for any reason other than nonpayment of premiums, you have the option to continue Personal Critical Illness Insurance and Dependent Critical Illness Insurance. To continue insurance under this section, you must:

(1) notify the Company within 31 days of the date the insurance would otherwise end; and
(2) pay the applicable premium to the Company.

Portability is not available when insurance terminates solely because your spouse or child ceases to be an eligible Dependent.

Insurance continued under this section ends on the earliest of:

(1) the last day of the period for which you paid premiums; or
(2) the date the Company receives a written request from you to terminate the insurance; or
(3) the date you attain age 90, or die.

INDIVIDUAL TERMINATION. Termination will have no effect on benefits payable for claims incurred by you while you were insured under the Policy.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE

DEPENDENT means your:

(1) legal spouse, who is not legally separated from you;
(2) child less than 26 years of age; or
(3) child age 26 years or older, who is:
    (a) continuously unable to earn a living because of a physical or mental disability; and
    (b) chiefly dependent upon you for support and maintenance.

    The child must be covered by the Group Policyholder's Critical Illness plan on the day before insurance would otherwise end due to his or her age. Proof of the total disability must be sent to the Company:
    (a) within 31 days of the day insurance would otherwise end due to age; and
    (b) thereafter, when the Company requests (but not more than once every two years).

Dependent will also include a child that you are required to provide insurance for under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under, and having the force and effect of, state law and which satisfies the QMCSO requirements of ERISA (section 609a).

"Child" includes:

(1) your natural child, legally adopted child, or stepchild;
(2) a child placed with you for the purpose of adoption, from the date of placement;
(3) a child for whom you are required by court order to provide Critical Illness insurance;
(4) a grandchild who resides in your household; and who is in your legal custody;
(6) a foster child for whom you have assumed full parental responsibility and control.

ELIGIBILITY. You become eligible to enroll for Dependent Critical Illness Insurance on the latest of:

(1) the date you become eligible for Personal Critical Illness Insurance;
(2) the issue date of the Policy; or
(3) the date you first acquire a Dependent.

You again become eligible to enroll for Dependent Critical Illness Insurance under the Policy during any Annual/Open Enrollment Period.

You must be insured for Personal Critical Illness Insurance to insure your Dependents. Dependents to be insured by the Policy must be enrolled in and approved for the same plan of benefits as you.

ELIGIBILITY AND EFFECTIVE DATES FOR DEPENDENT CRITICAL ILLNESS INSURANCE (Continued)

ANNUAL/OPEN ENROLLMENT PERIOD. You again become eligible to enroll, re-enroll, or change benefit options for Dependent Critical Illness Insurance under the Policy during the Group Policyholder's Annual/Open Enrollment Period.

EFFECTIVE DATES. Except as provided in the NEW DEPENDENTS section, Dependent Critical Illness Insurance will become effective on the latest of:

(1) the Policy Anniversary Date immediately following the Annual/Open Enrollment Period in which you become eligible for Dependent Critical Illness Insurance; or
(2) the first day of the Insurance Month coinciding with or next following the date you make written application for Dependent Critical Illness Insurance and pay the required Dependent premium to the Company; or
(3) the first day of the Insurance Month coinciding with or next following the date the Company approves any Evidence of Insurability, if required. (See Schedule of Benefits).

COURT ORDERED COVERAGE. If insurance is provided to a child based on a court order which requires you to provide Critical Illness benefits for the child, the insurance will become effective on the date stated in the court order; subject to:

(1) any eligibility and Evidence of Insurability requirements set forth in the Policy; and
(2) payment of any additional premium.

NEW DEPENDENTS. If additional premium is required to add a new Dependent, coverage for the new Dependent will become effective on the date the Dependent is acquired; provided:

(1) you complete a written application; and
(2) the additional premium is paid to the Company;

within 31 days of the date the Dependent is acquired.

If additional premium is not required, coverage for a new Dependent will become effective on the date the Dependent is acquired.

EXCEPTION FOR NEWBORN. If you acquire a newborn Dependent child, the child will be automatically insured from birth to the first 31 days or until the newborn is well enough to be discharged from the hospital, whichever period is longer. If you elect not to enroll the newborn child and pay any additional premium within the automatic coverage period, the newborn child's insurance will terminate.

TERMINATION OF DEPENDENT CRITICAL ILLNESS INSURANCE

TERMINATION. Critical Illness Insurance on a Dependent will cease on the earliest of:

(1) the date he or she ceases to be an eligible Dependent, as defined in the Policy;
(2) with respect to any category shown in the Schedule of Benefits, the date benefits payable reach the overall maximum for that category; or
(3) the date he or she ceases to be covered under at least one category other than the Wellness Category.

Dependent Critical Illness Insurance will cease for all of your Dependents on the earliest of:

(1) the date your Critical Illness Insurance terminates;
(2) the date Dependent Critical Illness Insurance is discontinued under the Policy;
(3) the date you cease to be in a class eligible for Dependent Critical Illness Insurance;
(4) the date you request that the Dependent Critical Illness Insurance be terminated;
(5) with respect to a benefit or a specific type of benefit, the date the portion of the Policy providing that type of benefit terminates; or
(6) the date through which premium has been paid on behalf of the Insured Dependents.

SURVIVING DEPENDENTS. If Personal Critical Illness Insurance terminates due to your death, Dependent Critical Illness Insurance may be continued:

(1) for three Insurance Months; or any longer period, if required by state or federal law;
(2) provided the Group Policyholder submits the premium on behalf of the surviving Dependents; and the Policy remains in force.

REINSTATEMENT OF DEPENDENT INSURANCE If you reinstate your Personal Critical Illness Insurance, you may also reinstate Dependent Critical Illness Insurance at the same time. To do so, you must follow the same requirements that apply in the reinstatement of your Personal Critical Illness Insurance.

DEPENDENT TERMINATION. Termination will have no effect on benefits payable for claims incurred by the Insured Dependent while he or she was insured under the Policy.

CRITICAL ILLNESS BENEFITS

GENERAL CRITICAL ILLNESS BENEFITS. The Company will pay a Critical Illness Benefit if you or an Insured Dependent sustains an Event/Illness shown in the Schedule of Benefits while covered under the Policy.

Benefit amounts payable are shown in the Schedule of Benefits.

For each Insured Person or Insured Dependent, the lifetime total benefits payable in any category shown in the Schedule of Benefits (except the Wellness Category) are subject to an overall maximum, as shown in the Schedule of Benefits. Certain Events/Illnesses are also subject to separate lifetime maximums, as shown in the Schedule of Benefits. If benefits paid to you or an Insured Dependent reach the overall maximum for a category, your or your Insured Dependent's coverage for that category will terminate.

Except for the Wellness Category, benefits are not payable if an Event/Illness shown in the Schedule of Benefits occurs within:

(1) 180 days of another Event/Illness in the same category; or
(2) 90 days of an Event/Illness in a different category.

If you or your Insured Dependent sustains two or more Events/Illnesses simultaneously, the highest applicable benefit is payable. Certain Events/Illnesses are only payable once per your or your Insured Dependent's lifetime, as shown in the Schedule of Benefits.

CRITICAL ILLNESS ASSESSMENT BENEFIT. The Company will pay a Critical Illness Assessment Benefit to an Insured Person or Insured Dependent who has one of the following Critical Illness Assessment Tests:

(1) abdominal aortic aneurysm ultrasound;
(2) blood test for triglycerides;
(3) bone marrow testing;
(4) bone density screening;
(5) breast ultrasound;
(6) CA 15-3 (blood test for breast cancer);
(7) CA125 (blood test for ovarian cancer);
(8) carotid ultrasound;
(9) CEA (blood test for colon cancer);
(10) chest x-ray;
(11) colonoscopy;
(12) CT Angiography;
(13) EKG;
(14) double contrast barium enema;
(15) fasting blood glucose test;
(16) flexible sigmoidoscopy;
(17) hemoccult stool analysis;
(18) mammography;
(19) pap smear;
(20) PSA (blood test for prostate cancer);
(21) serum cholesterol HDL/LDL;
(22) serum protein electrophoresis (blood test for myeloma);
(23) stress test; or
(24) thermography.

The Critical Illness Assessment Test must be performed during the Critical Illness Assessment Period as shown in the Schedule of Benefits, while your or your Insured Dependent's coverage under the Policy is in effect. The Critical Illness Assessment Benefit is subject to the maximums shown in the Schedule of Benefits.

CHILD CARE EXPENSE BENEFIT. The Company will pay a Child Care Expense Benefit if you or your Insured Dependent Spouse incurs Child Care Expenses while confined as an Inpatient in a Hospital or Alternate Care or Rehabilitative Facility for an Event/Illness shown in the Schedule of Benefits.

"**Child Care Expense**" means an expense for the care of a Child, charged by a licensed care provider who:
(1) is not a member of your immediate family; and
(2) is not living in your home.

"**Child,**" as used in the Child Care Expense Benefit, means your naturally born child, legally adopted child, stepchild, foster child, or child for whom you are the legal guardian, if the child is:
(1) less than age 16 and living with you; or
(2) age 16 years or older, who is:
    (a) unmarried;
    (b) living with you; and
    (c) incapable of independent living due to a mental or physical condition.

Amount. The amount of the Child Care Expense Benefit is shown in the Schedule of Benefits.

Proof. You must submit to the Company satisfactory proof that a Child Care Expense has been incurred for a Child (as defined in this provision) and paid by you or your Insured Dependent Spouse. Satisfactory proof is a signed receipt from the Child care provider showing:
(1) Child name;
(2) Child age;
(3) dates of care;
(4) total charges for care;
(5) total payments for care; and
(6) provider name, address, telephone number, and Federal Employer Identification Number/Taxpayer Identification Number.

Duration. The Child Care Expense Benefit will be payable for up to a maximum of 30 days from the date you or your Insured Dependent Spouse were confined as an Inpatient in a Hospital. This Benefit will cease on the earliest of:
(1) the date you or your Insured Dependent Spouse is released from Inpatient treatment;
(2) the date your or your Insured Dependent Spouse's Child(ren) no longer meet(s) the definition of Child in this provision; or
(3) the date the maximum duration ends.

EXCLUSIONS

GENERAL EXCLUSIONS. Benefits are not payable for any Event/Illness or loss resulting, directly or indirectly, from or in any degree caused by:

(1) intentional self-inflicted injury, self-destruction, or suicide, or any attempt thereof; whether sane or insane;
(2) participation in, commission of or attempt to commit a felony;
(3) war or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion of any kind;
(4) duty as a member of any military, including Reserves or National Guard; or
(5) an Event/Illness sustained while residing outside the United States, U.S. Territories, Canada, or Mexico for more than 12 months.

Benefits are also not payable while you or your Insured Dependent is incarcerated in any type of penal or detention facility.

BENEFICIARY

PAYMENTS TO BENEFICIARY. At your death, any amount payable under the Policy will be paid to the named Beneficiary who survives you. If you have not named a Beneficiary, or if no named Beneficiary survives you; then payment will be made to your:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving sibling or siblings in equal shares; or, if none
(5) estate.

In determining who is to receive payment, the Company may rely upon an affidavit by a member of the class to receive payment. Unless the Company receives written notice at its Group Insurance Service Office of a valid claim by some other person before paying the proceeds, the Company will make payment based upon the affidavit it has received. Such payment will release the Company from any further obligation for the death benefit.

The amount payable to anyone shown above will be reduced by any amount paid in accord with the Facility of Payment section.

If the person who would otherwise receive payment dies:

(1) within 15 days of your death; and
(2) before the Company receives satisfactory proof of your death;

payment will be made as if you had survived that person; unless other provisions have been made.

NAMING THE BENEFICIARY. Your Beneficiary will be as shown on your enrollment form, unless changed. If the Policy replaces a group policy providing similar coverages; then your beneficiary named under the prior policy will be the Beneficiary under the Policy, until changed.

CHANGING THE BENEFICIARY. Only you or your assignee may change the Beneficiary. A new Beneficiary may be named by filing a written notice of the change with the Company at its Group Insurance Service Office prior to your death. The change will be effective as of the date it was signed; subject to any action taken by the Company before it received notice of the change.

FACILITY OF PAYMENT. If any benefit under the Policy becomes payable to your estate, a minor, or any person who (in the Company's opinion) is not competent to give a valid release; then the Company, at its option, may make payment to any one or more of the following:

(1) a person who has assumed the care and support of you or a Beneficiary;
(2) a person who has incurred expense as a result of your last illness or death;
(3) the personal representative of your estate; or
(4) any person related by blood or marriage to you.

No payment made to anyone named above may exceed $1,000. Any payment made in good faith under this section will fully discharge the Company to the extent of the payment.

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of claim must be given within 20 days after a claim is incurred; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

(1) the Group Policyholder's name and Policy number;
(2) your name, address and certificate number, if available; and
(3) the patient's name and relationship to you.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof within 15 days. If the Company does not send the forms within 15 days; then you may send the Company written proof of claim in a letter and the claimant will be deemed to have complied with the requirements of this provision. The letter should state the nature, date and cause of the claim.

Proof of Claim. The Company must be given written proof of claim within 90 days after a claim is incurred; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must include:

(1) the nature, date and cause of the claim;
(2) a description of the services provided; and
(3) a signed authorization for the Company to obtain more information.

Within 15 days after receiving the first proof of claim, the Company may send a written acknowledgment. It will request any missing information or additional items needed to support the claim. This may include:

(1) any study models, treatment records or charts;
(2) copies of any x-rays or other diagnostic materials; and
(3) any other items the Company may reasonably require.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.

These time limits will not apply while the claimant lacks legal capacity.

PHYSICAL EXAMS. While a Critical Illness claim is pending, the Company may have the claimant examined:

(1) by a Physician of its choice;
(2) as often as is reasonably required.

In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. Any Critical Illness benefits payable under the Policy will be paid immediately after the Company receives complete proof of claim and confirms liability.

TO WHOM PAYABLE. All benefits payable under the Policy, including any benefits for Insured Dependents, will be paid to you, while living, unless:

(1) an overpayment has been made and the Company is entitled to reduce future benefits; or
(2) state or federal law requires that benefits be paid to a Insured Dependent child's custodial parent or custodian.

If any benefits remain to be paid after your death, such benefits will be paid in accord with the Beneficiary provision.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how the claimant may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within 90 days after receiving the first proof of a Critical Illness claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected.

In any event, the Company must send written notice of its decision within 180 days after receiving the first proof of a Critical Illness claim. If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within 60 days after receiving a denial notice of a Critical Illness claim. To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

For a Critical Illness claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under the Policy, the claimant must first seek two administrative reviews of the adverse claim decision, in accord with this section. If an ERISA claimant brings legal action under Section 502(a) of ERISA after the required reviews; then the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from any person to or for whom payments were made.

Such reimbursement is required whether the overpayment is due to:

(1) the Company's error in processing a claim;
(2) the claimant's receipt of benefits or services under another plan;
(3) fraud or any other reason.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder, the Company has the authority to:

(1) manage the Policy and administer claims under it; and
(2) interpret the provisions and to resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

(1) establish and enforce procedures for administering the Policy and claims under it;
(2) determine eligibility for insurance and entitlement to benefits;
(3) determine what information the Company reasonably requires to make such decisions; and
(4) resolve all matters when a claim review is requested.

The claimant has the right to:

(1) request a state insurance department review; or
(2) bring legal action.

SUMMARY OF THE LOUISIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of Louisiana who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Louisiana Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the Guaranty Association is limited. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Louisiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned upon residence in this state. Other conditions may also preclude coverage.

Insurance companies and insurance agents are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on the availability of coverage under the Louisiana Life and Health Insurance Guaranty Association when selecting an insurer.

The Louisiana Life and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

LLHIGA
P.O. Drawer #44126
Baton Rouge, Louisiana 70804

Department of Insurance
P.O. Box #94214
Baton Rouge, Louisiana 70814-9214

The state law that provides for this safety-net coverage is called the Louisiana Life and Health Insurance Guaranty Association Law. The following is a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions of the Law; nor does it in any way change any person's rights or obligations under the Law or the rights or obligations of the Guaranty Association.

COVERAGE. Generally, individuals will be protected by the Louisiana Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Louisiana. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE. However, persons holding such policies are not protected by this association, if:

(1) they are eligible for protection under the laws of another state (this may occur when insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);

(2) the insurer was not authorized to do business in Louisiana;

(3) their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contract holder;

(6) employer's plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);

(7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;

(8) any obligation that does not arise under the express written terms of the policy or contract;

(9) any policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or Part D coverage.

Other exclusions may also be applicable depending upon the issuing insurer, the policy itself, the policyholder or policy owner, or other factors. For more information, see the Louisiana Life and Health Insurance Guaranty Law, Louisiana Revised Statutes R.S. 22:2081 *et seq*.

LIMITS ON AMOUNT OF COVERAGE. The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $500,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $500,000 limit, the Association will not pay more than $100,000 in cash surrender values, $500,000 in health insurance benefits, $250,000 in present value of annuities, or $300,000 in life insurance death benefits -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

Lincoln Financial Group℠

LINCOLN FINANCIAL GROUP® PRIVACY PRACTICES NOTICE

The Lincoln Financial Group companies* are committed to protecting your privacy. To provide the products and services you expect from a financial services leader, we must collect personal information about you. **We do not sell your personal information to third parties.** We share your personal information with third parties as necessary to provide you with the products or services you request and to administer your business with us. This Notice describes our current privacy practices. While your relationship with us continues, we will update and send our Privacy Practices Notice as required by law. Even after that relationship ends, we will continue to protect your personal information. **You do not need to take any action because of this Notice, but you do have certain rights as described below.**

INFORMATION WE MAY COLLECT AND USE

We collect personal information about you to help us identify you as our customer or our former customer; to process your requests and transactions; to offer investment or insurance services to you; to pay your claim; or to tell you about our products or services we believe you may want and use. The type of personal information we collect depends on the products or services you request and may include the following:

- **Information from you:** When you submit your application or other forms, you give us information such as your name, address, Social Security number; and your financial, health, and employment history.

- **Information about your transactions:** We keep information about your transactions with us, such as the products you buy from us; the amount you paid for those products; your account balances; and your payment history.

- **Information from outside our family of companies**: If you are purchasing insurance products, we may collect information from consumer reporting agencies such as your credit history; credit scores; and driving and employment records. With your authorization, we may also collect information, such as medical information from other individuals or businesses.

- **Information from your employer**: If your employer purchases group products from us, we may obtain information about you from your employer in order to enroll you in the plan.

HOW WE USE YOUR PERSONAL INFORMATION

We may share your personal information within our companies and with certain service providers. They use this information to process transactions you have requested; provide customer service; and inform you of products or services we offer that you may find useful. Our service providers may or may not be affiliated with us. They include financial service providers (for example, third party administrators; broker-dealers; insurance agents and brokers, registered representatives; reinsurers and other financial services companies with whom we have joint marketing agreements). Our service providers also include non-financial companies and individuals (for example, consultants; vendors; and companies that perform marketing services on our behalf). Information we obtain from a report prepared by a service provider may be kept by the service provider and shared with other persons; however, we require our service providers to protect your personal information and to use or disclose it only for the work they are performing for us, or as permitted by law.

When you apply for one of our products, we may share information about your application with credit bureaus. We also may provide information to group policy owners, regulatory authorities and law enforcement officials and to others when we believe in good faith that the law requires disclosure. In the event of a sale of all or part of our businesses, we may share customer information as part of the sale. **We do not sell or share your information with outside marketers who may want to offer you their own products and services; nor do we share information we receive about you from a consumer reporting agency. You do not need to take any action for this benefit.**

SECURITY OF INFORMATION

We have an important responsibility to keep your information safe. We use safeguards to protect your information from unauthorized disclosure. Our employees are authorized to access your information only when they need it to provide you with products, services, or to maintain your accounts. Employees who have access to your personal information are required to keep it confidential. Employees are trained on the importance of data privacy.

Questions about your personal information should be directed to:

Lincoln Financial Group
Attn: Enterprise Services Compliance-Privacy, 7C-01
1300 S. Clinton St.
Fort Wayne, IN 46802

Please include all policy/contract/account numbers with your correspondence.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Financial Investment Services Corporation
Lincoln Investment Advisors Corporation
Lincoln Life & Annuity Company of New York
Lincoln Variable Insurance Products Trust
The Lincoln National Life Insurance Company

ADDITIONAL PRIVACY INFORMATION FOR INSURANCE PRODUCT CUSTOMERS

CONFIDENTIALITY OF MEDICAL INFORMATION

We understand that you may be especially concerned about the privacy of your medical information. We do not sell or rent your medical information to anyone; nor do we share it with others for marketing purposes. We only use and share your medical information for the purpose of underwriting insurance, administering your policy or claim and other purposes permitted by law, such as disclosure to regulatory authorities or in response to a legal proceeding.

MAKING SURE MEDICAL INFORMATION IS ACCURATE

We want to make sure we have accurate information about you. Upon written request we will tell you, within 30 business days, what personal information we have about you. You may see a copy of your personal information in person or receive a copy by mail, whichever you prefer. We will share with you who provided the information. In some cases we may provide your medical information to your personal physician. We will not provide you with information we have collected in connection with, or in anticipation of, a claim or legal proceeding. If you believe that any of our records are not correct, you may write and tell us of any changes you believe should be made. We will respond to your request within 30 business days. A copy of your request will be kept on file with your personal information so anyone reviewing your information in the future will be aware of your request. If we make changes to your records as a result of your request, we will notify you in writing and we will send the updated information, at your request, to any person who may have received the information within the prior two years. We will also send the updated information to any insurance support organization that gave us the information, and any service provider that received the information within the prior 7 years.

Questions about your personal medical information should be directed to:

Lincoln Financial Group
Attn: Medical Underwriting
P.O. Box 21008
Greensboro, NC 27420-1008

The CONFIDENTIALITY OF MEDICAL INFORMATION and MAKING SURE INFORMATION IS ACCURATE sections of this Notice apply to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company

Lincoln Financial Group℠

LINCOLN FINANCIAL GROUP® PRIVACY NOTICE FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You have received this Notice because you have applied for, or currently have, insurance coverage or an annuity ("Coverage"), that contains benefit provisions subject to the federal privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act, as amended ("HIPAA"). This is Coverage that has been, or will be issued with one of the Lincoln Financial Group insurance companies* ("Company"). This Notice refers to the Company by using the terms "us," "we," or "our." We value our relationship with you and are committed to protecting the confidentiality and security of information we collect about you, especially health information.

We collect, use and disclose information about you to evaluate and process any requests for coverage and claims for benefits you may make regarding your Coverage. This notice describes how we protect the protected health information we have about you which relates to your Coverage ("Protected Health Information"), and how we may use and disclose this information. Protected Health Information includes individually identifiable information that relates to your past, present or future health, treatment or payment for health care services. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required to provide you with this Notice in accordance with federal health privacy regulations that were issued as a result of HIPAA. We are required by law to maintain the privacy of your Protected Health Information; to provide you this Notice of our legal duties and privacy practices with respect to your Protected Health Information; and to follow the terms of this Notice.

We reserve the right to change the terms of this Notice. Any such changes will apply to all Protected Health Information we already have about you as well as any Protected Health Information we may receive in the future. If we make a material change to the terms of the Notice, we will promptly send the revised Notice to you should you still maintain coverage with us when the revised Notice becomes effective.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following describes when we may use and disclose your Protected Health Information with your written authorization and without your authorization:

Authorization: Except as described below, we will not use or disclose your Protected Health Information for any reason unless we have a signed authorization from you or your legal representative to use or disclose your Protected Health Information. You or your legal representative has the right to revoke an authorization in writing, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage.

Treatment: We may use and disclose your Protected Health Information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request Protected Health Information that we hold about you in order to make decisions about your care.

Payment of Claims: We may use and disclose your Protected Health Information to pay for benefits under your Coverage. For example, when you present a claim for benefits, we may obtain medical records from the doctor or health facility involved in your care to determine if you are eligible for benefits under the insurance policy and to reimburse you for services provided. Other payment-related uses and disclosures that are permitted and we may engage in include: making claim decisions, coordinating benefits with other insurers or payers, billing, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.

Health Care Operations: We may use and disclose your Protected Health Information for our insurance operations. Our insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of Coverage, or for reinsurance purposes. For example, when you apply for insurance we may collect medical information from your doctor (health care provider) or a medical facility that provided you health care services to determine if you qualify for insurance. We may also use and disclose Protected Health Information to conduct or arrange for medical review, legal services, contract for reinsurance, business planning and development regarding the management and operation of our Coverage processes, or auditing, including fraud and abuse detection and compliance programs. Protected Health Information may also be disclosed for customer service, servicing our current and future customer relationships permitted by law, resolution of internal grievances and as part of a potential sale, transfer, merger, or consolidation in order to make an informed business decision regarding any such prospective transaction. For group plans Protected Health Information may be disclosed to your Plan Sponsor for purposes of administering your Plan or other health plan maintained by your employer to facilitate claims payments under the plan.

Business Associates: We may also disclose Protected Health Information to non-affiliated business associates, but only if the receipt of Protected Health Information is necessary to provide a service to us and the business associate agrees to protect the Protected Health Information according to HIPAA rules. Examples of business associates are: billing companies, data processing companies, auditors, claims processing companies and companies that provide general administrative services.

Where Required by Law, for Public Health or Similar Activities: We may also disclose Protected Health Information where required by law, for public health or similar activities. Examples include:

- Releasing Protected Health Information to state or local health authorities, as required by law, of particular communicable diseases, injury, birth, death, and for other required public health investigations;
- Releasing Protected Health Information to a governmental agency or regulator with health care oversight responsibilities;
- Releasing Protected Health Information to a coroner, medical examiner or funeral director to assist in identifying a deceased individual or to determine the cause of death;
- Releasing Protected Health Information to public health or other appropriate authorities, as required by law, when there is reason to suspect abuse, neglect, or domestic violence;
- Releasing Protected Health Information to the Food and Drug Administration (FDA) for purposes related to quality, safety or effectiveness of FDA-regulated products or activities;
- Releasing Protected Health Information if required by law to do so by a court or administrative ordered subpoena or discovery request, or for law enforcement purposes as permitted by law. We will make efforts to notify you of such requests or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination;
- Releasing Protected Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- Releasing Protected Health Information if you are a member of the military as required by armed forces services;
- Releasing Protected Health Information to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Releasing Protected Health Information to worker's compensation agencies if necessary for your worker's compensation benefit determination;

- Releasing Protected Health Information to avert a serious threat to someone's health or safety, including the disclosure of Protected Health Information to government or privacy disaster relief or assistance agencies to allow such entities to carry out their responsibilities to specific disaster situations.
- Uses and Disclosures to Family, Friends or Others Involved in Your Care: With your written approval, we may disclose your Protected Health Information to designated family, friend, personal representative, or other individual that you may identify as involved in your care or involved in the payment for your care. Should you become incapacitated or be in the face of an emergency medical situation and not able to provide us with your written approval, we may disclose Protected Health Information about you that is directly relevant to such person's involvement in your care or payment for such care.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights as a consumer under HIPAA concerning the Protected Health Information we have about you in our records. Any request to exercise your rights as described below should be made in writing and sent to **Lincoln Financial Group, Attn: Enterprise Compliance – Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802.** Also, should you wish to terminate a request that has been accommodated, such termination request must also be in writing and sent to the same address listed above. Your request should include the following information: your full name, address, and policy number. Generally, we will respond to these requests within 30 days of receipt.

Right to Request Restrictions: You have the right to request that we restrict or limit our use or disclosure of your Protected Health Information that would otherwise be permitted for purposes related to treatment, payment or our health care operations, including disclosure to someone who may be involved in your care or payment for your care, like a family member, friend or personal representative. While we will consider your request, we are not required to agree to your restriction. If we do agree to the restriction, we will not use or disclose your Protected Health Information as requested but reserve the right to terminate the agreed to restriction if we deem appropriate. In your request to restrict use and disclosure, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

Right to Request Confidential Communications: You have the right to request that we communicate with you about Protected Health Information in a certain way or using a certain address or email address, if you make such a request in writing and send it to the address provided above. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Copy Your Protected Health Information: In most instances, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. Your request must be in writing and sent to the address provided above. We will deny inspection and copying of certain Protected Health Information, for example psychotherapy notes and Protected Health Information collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. We reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. In those limited circumstances that we deny your request to inspect and obtain a copy of your Protected Health Information, you have the right to request a review of our denial. Your request to review our denial should be submitted in writing and sent to the address provided above.

Right to Amend Your Protected Health Information: You have the right to request that we amend your Protected Health Information in our records if you believe it is inaccurate or incomplete. Your request must be in writing and sent to the address provided above. Your request must provide your reason(s) for seeking the amendment or correction. If an amendment or correction request is accepted, we will amend or correct all appropriate records as well as notify others with whom we have disclosed the erroneous Protected Health Information. We may deny your request if you ask us to amend Protected Health Information that is accurate and complete; was not created by us, unless the creator of Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. If we deny your request, we will provide you with an explanation for our denial and any further rights you may have regarding your request to amend.

Right to Receive an Accounting of Disclosures of Your Protected Health Information: You have the right to request an accounting or list of disclosures we have made of your Protected Health Information. This list will not include disclosures

- For treatment;
- For payment or health care operations;
- To law enforcement, for purposes of national security
- To department of corrections personnel;
- Pursuant to your authorization;
- or directly to you.

To request this list, you must submit your request in writing to the address provided above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We reserve the right to charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice upon request, even if you received this Notice electronically.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, you must submit a written complaint to the address provided above. You can be assured that the Company will not retaliate against you for filing a complaint.

For Further Information: For further information regarding this Notice or the Company's privacy practices, please contact **Lincoln Financial Group, Attn: Enterprise Compliance – Corporate Privacy Office - 7C-01, 1300 S Clinton Street, Fort Wayne IN 46802, or call 1-877-275-5462.**

Effective Date: This Notice is effective June 1, 2011.

*This information applies to the following Lincoln Financial Group companies:

First Penn-Pacific Life Insurance Company
Lincoln Life & Annuity Company of New York
The Lincoln National Life Insurance Company